

GASTROENTEROLOGY

2300 Southwood Drive, Nashua, NH 03063 PHONE 603-577-4081 FAX 603-577-4277

Today's Date: _____ Referring Provider: _____ PHONE: _____ FAX: _____

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

PCP: _____

****COMPLETE THE FOLLOWING INSURANCE INFORMATION or YOU MAY ATTACH A COPY OF THE PATIENTS DEMOGRAPHIC SHEET and INSURANCE CARD (front & back).**

Insurance: _____ ID# _____ Effective Date: _____

Ins. Address: _____ Phone #: _____ CO-PAY \$: _____

Subscriber Name: _____ DOB: _____ Relationship to Patient: _____

****If your Patient has a Managed Care Insurance Plan, please submit a referral and FAX to 603-577-4388**

DUAL REQUESTS – PLEASE INDICATE ORDER PREFERENCE (#1, #2)

OFFICE CONSULTATION

Please FAX ALL Office notes, Reports, Labs, etc. to 603-577-4277.

DIAGNOSIS: _____

TESTING DONE:

<input type="checkbox"/> EGD <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abnormal Radiographic Testing <input type="checkbox"/> Celiac Disease Confirmation <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Gastric Ulcer F/U <input type="checkbox"/> GERD <input type="checkbox"/> GI Bleed <input type="checkbox"/> Iron Deficiency <input type="checkbox"/> Screening Barrett's Esophagus	<input type="checkbox"/> DIAGNOSTIC COLONOSCOPY <input type="checkbox"/> Abnormal Radiographic Testing <input type="checkbox"/> Chronic Diarrhea <input type="checkbox"/> Chronic Constipation <input type="checkbox"/> FU Diverticulitis -after 2 mo TX completion <input type="checkbox"/> GI Bleed <input type="checkbox"/> Hemocult Positive Stool <input type="checkbox"/> Iron Deficiency <input type="checkbox"/> Personal HX Colon Cancer <input type="checkbox"/> Personal HX Colon Polyps	<input type="checkbox"/> SCREENING COLONOSCOPY OPTION 1: Attend our Group Informational Meeting AT 21 EAST HOLLIS STREET <input type="checkbox"/> FM HX Colon CA -1 st Degree relative or multiple 2 nd degree relatives <input type="checkbox"/> Previous screening colonoscopy- Year _____ <p style="text-align: center;">OR</p> OPTION 2: View our On-line Colonoscopy Information via the Internet: http://patients.d-h.org/nashuacolonoscopy
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INFORMATION NEEDED FOR PROCEDURES ONLY

RENAL / KIDNEY DISEASE?	YES	NO
DIABETES?	YES	NO
Taking COUMADIN?	YES	NO
May stop 5 days prior to procedure?	YES	NO
Taking PLAVIX, ASPIRIN, or NSAIDS?	YES	NO
May stop 7 days prior to procedure?	YES	NO